Intake Form for ACRA Relief Fund

This application will be kept strictly confidential. No personal information is shared with ACRA.

Name: ____________________________________ DOB: _________ Age: ____

Address: ____

Phone:_________________________ **Email:** ____________________________________

Gender: Male Female **Race/Ethnicity (check all that apply):** African American/Black Caucasian Asian/Pacific Hispanic Other: ______________________

Health Insurance: Medicare Medicaid PrivateCHAP Del Healthy Children (SCHIP) None

Adults in Household:
Adult 1 Age: ______ Adult 2 Age: ______ Adult 3 Age: ______ Adult 4 Age: ______

Children in Household:
Child 1 Age: ______ Child 2 Age: ______ Child 3 Age: ______ Child 4 Age: ______
Child 5 Age: ______ Child 6 Age: ______ Child 7 Age: ______ Child 8 Age: ______

Household Income: $_____________
Source of Income (*please circle all that apply*): FT employment PT employment SSI SSDI TANF Food Stamps General Assistance Unemployment SS/Pension
Other (specify): ____________________

Type of Request/Amount Requested:

- Food _____________
- Rent _____________
- Utilities _____________
- Car repairs _____________
- Medical expenses _____________
- Other _____________

Completed By ___________________________ Date _____________________

CCC Administrative Use Only

Date Received __________
Fund Approved? ________ Amount __________
Date Dispersed _________ Dispersed to ________________